U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 26 September 2005

In the Matter of:
SETH W. WILKINSON
Claimant

Case No.: 2004 BLA 5644

v.

JACKSON COUNTY MINING CORP.
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party in Interest

Appearances: Mr. Seth Wilkinson
Pro Se

Mr. Lance Yeager, Attorney
For the Employer

Before: Richard T. Stansell-Gamm
Administrative Law Judge

DECISION AND ORDER – DENIAL OF BENEFITS

This matter involves a claim filed by Mr. Seth Wilkinson for disability benefits under the Black Lung Benefits Act, Title 30, United States Code, Sections 901 to 945 ("the Act"). Benefits are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis, or to survivors of persons who died due to pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as "black lung" disease.

Procedural History

On November 12, 2002, Mr. Wilkinson filed a claim for black lung disability benefits under the Act (DX 1).[1] Following a pulmonary examination and consideration of the medical record, the District Director denied the claim on October 17, 2003 for failure to prove the

[1]The following notations appear in this decision to identify exhibits: DX – Director exhibit; EX – Employer exhibit; and, ALJ – Administrative Law Judge exhibit.

presence of pneumoconiosis (DX 19). Mr. Wilkinson appealed the adverse decision on November 5, 2003 (DX 20) and the case was forwarded to the Office of Administrative Law Judges on January 23, 2004 (DX 22) for a hearing. Pursuant to a Notice of Hearing, dated August 30, 2004 (ALJ I), I set a hearing date of November 8, 2004 for this case in Birmingham, Alabama. However, on September 7, 2004, indicating he was unable to obtain an attorney and had nothing more to present, Mr. Wilkinson stated that he would not attend the scheduled hearing. Instead, he asked that I "look over the record." Since the Employer did not object to a decision on the record, I cancelled the hearing, indicted the record contained DX 1 to DX 22, and gave the parties the opportunity to submit additional documentation for my consideration (ALJ II). On October 13, 2004, I received from the Employer's counsel nine exhibits, marked EX 1 to EX 9, which I now admit into evidence. My decision in this case is based on DX 1 to DX 22 and EX 1 to EX 9.

ISSUES

1. Whether Mr. Wilkinson has pneumoconiosis.

2. If Mr. Wilkinson has pneumoconiosis, whether his disease arose out of coal mine employment.

3. Whether Mr. Wilkinson has a totally disabling respiratory impairment.

4. If Mr. Wilkinson is totally disabled, whether his total disability was due to coal workers' pneumoconiosis.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Preliminary Findings

Born on July 13, 1939, Mr. Wilkinson married Mrs. Ann M. Wilkinson on November 14, 1992. Mr. Wilkinson started mining coal in 1978 in strip mines located in Alabama. He operated a bulldozer and scraper to remove the overburden from the coal seams. After a break in his coal mine employment of more than a year in 1983 and a portion of 1984, Mr. Wilkinson returned to coal strip mines in October 1984 and continued work through August 1985 when the mine shut down. Between 1958 and 1978, Mr. Wilkinson worked as a press operator in a stove manufacturing plant. He also worked several years after he left coal mining in building supply as a general laborer. On other occasions, he operated heavy equipment. (DX 2 to DX 7)

Issue #1 – Presence of Pneumoconiosis

"Pneumoconiosis" is defined as a chronic dust disease arising out of coal mine employment.[2] The regulatory definitions include both clinical, or medical, pneumoconiosis, defined as diseases recognized by the medical community as pneumoconiosis, and legal pneumoconiosis, defined as "any chronic lung disease arising out of coal mine employment."[3]

[2] 20 C.F.R. § 718.201 (a).
[3] 20 C.F.R. § 718.201 (a) (1) and (2) (emphasis added).

The regulation further indicates that a lung disease arising out of coal mine employment includes "any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment." 20 C.F.R. § 718.201 (b). As courts have noted, under the Act, the legal definition of pneumoconiosis is much broader than medical pneumoconiosis. *Kline v. Director, OWCP*, 877 F.2d 1175 (3d Cir. 1989).

According to 20 C.F.R. §718.202, the existence of pneumoconiosis may be established by four methods: chest x-rays (§ 718.202 (a)(1)), autopsy or biopsy report (§ 718.202 (a)(2)), regulatory presumption (§ 718.202 (a)(3)),[4] and medical opinion (§ 718.202 (a)(4)). Since the record does not contain evidence that Mr. Wilkinson had complicated pneumoconiosis, and he filed his claim after January 1, 1982, a regulatory presumption of pneumoconiosis is not applicable. Additionally, Mr. Wilkinson has not provided any biopsy evidence and obviously no autopsy has been accomplished. As a result, to demonstrate that he has pneumoconiosis, Mr. Wilkinson will have to rely on chest x-rays or medical opinion to establish the presence of pneumoconiosis.

Chest X-Rays

Date of x-ray	Exhibit	Physician	Interpretation
May 6, 1992	DX 11 & EX 9	Dr. Harnsberger	Old granulomatous disease, right lung.
May 26, 1992	DX 11 & EX 9	Dr. Harnsberger	Calcified granulomas, right lower lobe.
July 22, 1992	DX 11 & EX 9	Dr. Harnsberger	Calcified granulomas, right lower lobe.
September 23, 1992	DX 11 & EX 9	Dr. Harnsberger	Patchy infiltrate left lung; calcified granulomas, right lower lobe.
January 26, 1995	DX 11 & EX 9	Dr. Harnsberger	Old granulomatous disease; otherwise stable chest.
April 4, 1997	DX 11 & EX 9	Dr. Harnsberger	Calcified granuloma right lower lobe.
April 7, 1998	DX 11 & EX 9	Dr. Harnsberger	Calcified granulomas right lung, stable chest.
July 23, 1998	DX 11 & EX 9	Dr. Harnsberger	Stable chest
April 10, 2002	EX 5	Dr. Cochran	Emphysematous changes present; pneumonic changes in right middle lobe.
February 12, 2003	EX 5 & EX 9	Dr. Cochran	Mild emphysema present, calcified granuloma, right lower lobe.
(same)	EX 9	Dr. Harnsberger	Old granuloma.

[4]If any of the following presumptions are applicable, then under 20 C.F.R. § 718.202 (a)(3), a miner is presumed to have suffered from pneumoconiosis: 20 C.F.R. § 718.304 (if complicated pneumoconiosis is present then there is an irrebuttable presumption the miner is totally disabled due to pneumoconiosis); 20 C.F.R. § 718.305 (for claims filed before January 1, 1982, if the miner has fifteen years or more coal mine employment, there is a rebuttable presumption that total disability is due to pneumoconiosis); and 20 C.F.R. § 718.306 (a presumption when a survivor files a claim prior to June 30, 1982).

February 20, 2003	DX 9	Dr. Enjeti	Negative for pneumoconiosis; calcified granulomas present.
March 18, 2003	DX 11 & EX 9	Dr. Harnsberger	Granulomas, right lung.
April 7, 2003	DX 10	Dr. Harnsberger	Infiltrate right middle lobe.
April 14, 2003	EX 1 & EX 4	Dr. Wiot, BCR, B[5]	Negative for pneumoconiosis; emphysema present; clearing infiltrate.
May 20, 2003	DX 11 & EX 9	Dr. Harnsberger	Infiltrate right middle lobe.
June 26, 2003	DX 11 & EX 9	Dr. Harnsberger	Clearing of infiltrate in right lung.
March 9, 2004	EX 2 & EX 3	Dr. Goldstein, B	Negative for pneumoconiosis; emphysema present.

Since none of chest x-ray interpretations include a finding of pneumoconiosis, Mr. Wilkinson is unable to establish the presence of pneumoconiosis through radiographic evidence under 20 C.F.R. §718.202 (a) (1).

Medical Opinion

Although Mr. Wilkinson can not establish the presence of pneumoconiosis through chest x-ray evidence, he may still prove this requisite element of entitlement under 20 C.F.R. § 718.202 (a) (4) through the preponderance of the more probative medical opinion. To place the various assessments into perspective, a review of other medical test results is helpful

Pulmonary Function Tests

Exhibit	**Date / Doctor**	**Age / Height**	**FEV¹ pre[6] post[7]**	**FVC pre post**	**MVV pre post**	**% FEV¹ / FVC pre post**	**Qualified[8] pre Post**	**Comments**
DX 11 & EX 9	Jan. 26, 1995 Dr. Harnsberger	55 73”	1.09	2.75		40%	Yes[9]	Very severe obstruction
DX 11 & EX 9	Feb. 27, 1995 Dr. Harnsberger	56 73”	1.6	3.47		46%	Yes[10]	Severe obstruction

[5]The following designations apply: B – B reader, and BCR – Board Certified Radiologist. These designations indicate qualifications a person may posses to interpret x-ray film. A “B Reader” has demonstrated proficiency in assessing and classifying chest x-ray evidence for pneumoconiosis by successful completion of an examination. A “Board Certified Radiologist” has been certified, after four years of study and examination, as proficient in interpreting x-ray films of all kinds including images of the lungs. *See also* 20 C.F.R. § 718.202 (a) (1) (ii).

[6]Test result before administration of a bronchodilator.

[7]Test result following administration of a bronchodilator.

[8]Under 20 C.F.R. § 718.204 (b) (2) (i), to qualify for total disability based on pulmonary function tests, for a miner’s age and height, the FEV1 must be equal to or less than the value in Appendix B, Table B1 of 20 C.F.R. § 718, **and either** the FVC has to be equal or less than the value in Table B3, or the MVV has to be equal **or** less than the value in Table B5, or the ratio FEV1/FVC has to be equal to or less than 55%.

[9]The qualifying FEV1 number is 2.36 for age of 55 and 73”; the corresponding qualifying FVC value is 2.98.

DX 11 & EX 9	Apr. 4,1997 Dr. Harnsberger	57 73”	1.04	2.97		35%	Yes[11]	Severe obstruction
DX 11 & EX 9	Apr. 7, 1998 Dr. Harnsberger	58 73”	1.27	3.5		40%	Yes[12]	Severe obstruction
DX 11 & EX 9	Aug. 18, 1998 Dr. Harnsberger	59 73”	1.30 1.48	3.7 3.61		41% 41%	Yes[13]	Severe obstruction
DX 11 & EX 9	Sep. 29, 1998 Dr. Harnsberger	59 73”	1.18	3.2		37%	Yes	Severe obstruction
EX 5	Feb. 17, 2003 Dr. Saxena	63 73”	1.15 1.11	2.52 2.45	35 40	46% 45%	Yes[14]	Severe obstructive lung defect
DX 9 & EX 7	Feb. 20, 2003 Dr. Enjeti	63 73”	0.80 0.86	1.92 2.05		41% 42%	Yes	Severe obstructive disease
DX 11 & EX 9	Mar. 18, 2003 Dr. Harnsberger	63 73”	1.19	2.78		43%	Yes	Severe obstructive disease
DX 11 & EX 9	Apr. 7, 2003 Dr. Harnsberger	63 73”	0.86	2.41		36%	Yes	Very severe obstruction
DX 10	Apr. 14, 2003 Dr. Harnsberger	63 73”	1.07 1.11	2.4 2.58		44% 43%	Yes Yes	Severe chronic obstructive disease
DX 11 & EX 9	Jun. 26, 2003 Dr. Harnsberger	63 73”	0.96	2.51		38%	Yes	Severe obstruction
EX 3	Mar. 9, 2004 Dr. Goldstein	64 71”	1.21 1.38	2.3 2.61	42 46	53% 53%	Yes[15] Yes	Moderate to severe obstruction

[10]The qualifying FEV1 number is 2.34 for age of 56 and 73”; the corresponding qualifying FVC value is 2.97.

[11]The qualifying FEV1 number is 2.33 for age of 57 and 73”; the corresponding qualifying FVC value is 2.95.

[12]The qualifying FEV1 number is 2.31 for age of 58 and 73”; the corresponding qualifying FVC value is 2.93.

[13]The qualifying FEV1 number is 2.29 for age of 59 and 73”; the corresponding qualifying FVC value is 2.91.

[14]The qualifying FEV1 number is 2.23 for age of 63 and 73”; the corresponding qualifying FVC value is 2.84.

[15]The qualifying FEV1 number is 2.06 for age of 64 and 71″; the corresponding qualifying FVC and MVV values are 2.63 and 82, respectively.

Arterial Blood Gas Studies

Exhibit	Date / Doctor	pCO^2 (rest) pCO^2 (exercise)	pO^2 (rest) pO^2 (exercise)	Qualified[16]	Comments
EX 5 & EX 6	Feb. 15, 2001 Dr. Crystal	41.7	74.6	No[17]	
EX 5	Feb 17, 2003 Dr. Saxena	36.8	68.8	No[18]	(During hospitalization)
DX 9 & EX 7	Feb. 20, 2003 Dr. Enjeti	34.1	71	No[19]	Mild hypoxemia
EX 3	Mar. 9, 2004 Dr. Goldstein	38 39	84 86	No[20] No[21]	

CT Scan
(EX 1, EX 4, EX 5, and EX 9)

On February 13, 2003, as part of Mr. Wilkinson's hospitalization for heart problems, a CT scan was obtained of his chest. Dr. Cochran interpreted the study and found a small calcified granuloma in the right lower lobe and "changes of COPD with some mild interstitial fibrotic changes." Otherwise, the CT scan was negative.

Dr. Jerome Wiot, a board certified radiologist, evaluated the same CT scan and specifically found no evidence of coal workers' pneumoconiosis.

Dr. Suresh Enjeti
(DX 9)

On February 20, 2003, Dr. Enjeti conducted a pulmonary examination. Mr. Wilkinson reported chronic shortness of breath at rest and upon exercise. He never smoked cigarettes and had been hospitalized for recurrent pneumonia and heart problems.

Upon physical examination, Dr. Enjeti heard diminished chest sounds. The chest x-ray revealed calcified granulomas. The pulmonary function test indicted the presence of a severe obstructive pulmonary disease. The arterial blood gas study showed mild hypoxemia. Dr. Enjeti diagnosed a severe obstructive airways disease, possible asthma, possible recurrent infectious lung disease, and CHF (congestive heart failure).

[16]To qualify for Federal Black Lung Disability benefits at a coal miner's given pCO^2 level, the value of the coal miner's pO^2 must be equal to or less than corresponding pO^2 value listed in the Blood Gas Tables in Appendix C for 20 C.F.R. § 718.

[17]For the pCO^2 of 40 to 49, the qualifying pO^2 is 60, or less.

[18]For the pCO^2 of 37 or below, the qualifying pO^2 is 63, or less.

[19]For the pCO^2 of 34 or below, the qualifying pO^2 is 66, or less.

[20]For the pCO^2 of 38 or below, the qualifying pO^2 is 62, or less.

[21] For the pCO^2 of 39 or below, the qualifying pO^2 is 61, or less.

Dr. B. Daniel Harnsberger
(DX 10, DX. 11, and EX 9)

Since May 1992 when Mr. Wilkinson presented with chronic obstructive airways disease, asthmatic bronchitis, and left lung pneumonia, Dr. Harnsberger has periodically treated Mr. Wilkinson's pulmonary problems with office visits occurring once or twice a year, with a significant gap in treatment between 1998 and March 2003. At the time of his first office visit, Mr. Wilkinson had been a strip coal miner for about five years, operated a press for eighteen years and currently was in the building supply business for six years. According to the physician, Mr. Wilkinson was "essentially a non-smoker." Over the course of years, as demonstrated by multiple pulmonary function tests, Mr. Wilkinson's severe pulmonary obstruction has worsened. For a week in April 2003, Mr. Wilkinson was hospitalized for pneumonia and severe COPD (chronic obstructive pulmonary disease). According to Dr. Harnsberger, Mr. Wilkinson's pulmonary condition is due to asthmatic bronchitis and post-inflammatory airways disease. Although Mr. Wilkinson had been a coal miner for five years, a press operator for eighteen years, and a building supply laborer for over twelve years, Dr. Harnsberger was "unable to correlate any of his respiratory illness secondary to occupational exposure."[22] Nevertheless, Mr. Wilkinson was totally disabled since continued exposure to coal dust was "contraindicated." Additionally, based on the absence of definitive clinical and test findings, Dr. Harnsberger was not confident diagnosing congestive heart failure.

Dr. Allan R. Goldstein
(EX 2 and EX 4)

On March 9, 2004, Dr. Goldstein, board certified in pulmonary disease and internal medicine, evaluated Mr. Wilkinson's pulmonary condition. Mr. Wilkinson had worked on coal strip mines for five to six years. He had retired two years before the date of examination from a lumber supply company. Mr. Wilkinson stated he never smoked cigarettes.[23] For the past seventeen years, he has struggle with chronic shortness of breath. A review of his medical record showed a history of chronic obstructive pulmonary disease, congestive heart failure, and episodes of pneumonia.

When examining Mr. Wilkinson's chest, Dr. Goldstein heard decreased breath sounds and observed his difficult breathing. The chest x-ray was negative for pneumoconiosis. Although the arterial blood gas study was normal, Mr. Wilkinson could only exercise for a little over two minutes. The pulmonary function studies established the presence of a moderate to severe obstructive airways disease which precluded Mr. Wilkinson's return to coal mine employment. According to Dr. Goldstein, Mr. Wilkinson did not have coal workers' pneumoconiosis. While he was uncertain of the cause of the obstructive pulmonary impairment, Dr. Goldstein did not believe it was related to Mr. Wilkinson's coal mine employment based on the characteristics of pulmonary test results.

[22]In one pulmonary function test, Dr. Harnsberger also annotated ten years exposure to DDT.

[23]While Mr. Wilkinson stated he never smoked cigarettes, Dr. Goldstein noted at least one reference in Mr. Wilkinson's hospitalization records to prior cigarette use. According to Dr. Goldstein, cigarette smoking can cause obstructive airways disease.

Medical and Hospital Records
(EX 5)

On April 10, 2002, Dr. Frederico Fernandez admitted Mr. Wilkinson into the Dekalb Baptist Medical Center for a three day treatment of pneumonia and exacerbation of chronic obstructive pulmonary disease. In the social history for Mr. Wilkinson, Dr. Fernandez annotated, "used to smoke some cigarettes." Upon resolution of the pneumoconiosis, Mr. Wilkinson was released from the hospital.

On June 15, 2002, Dr. Danny M. Mince admitted Mr. Wilkinson into the hospital for worsening shortness of breath. The chest x-ray showed "COPD changes, but no infiltrates." Blood oxygen saturation was abnormal. Dr. Mince diagnosed exacerbation of COPD and hypertension.

Between February 12 and 18, 2003, Dr. Sanjeev Saxena treated Mr. Wilkinson in the Dekalb Baptist Medical Center for heart failure, established by blood tests. Mr. Wilkinson presented to the hospital with worsening shortness of breath. In his treatment notes, Dr. Saxena reported, "the patient is an ex-smoker." Mr. Wilkinson also had a history of black lung, COPD/emphysema, congestive heart failure, and HTN (hypertension). A chest x-ray and CT scan showed a "stable" chest with mild emphysema and calcified granuloma. The chest examination revealed bilateral rales. The pulmonary function study showed a severe pulmonary obstruction. In the treatment notes and as a discharge diagnosis, Dr. Saxena included "black lung." The physician also diagnosed congestive heart failure and chronic obstructed airways. Mr. Wilkinson was placed on oxygen therapy.

Discussion

Dr. Saxena diagnosed black lung disease. The remaining physicians to treat Mr. Wilkinson did not reach a similar conclusion.

Due to this conflict of medical opinion, I must assess the probative value of the respective opinion in terms of reasoning and documentation. As to the first factor, a physician's medical opinion is likely to be more comprehensive and probative if it is based on extensive objective medical documentation such as radiographic tests and physical examinations. *Hoffman v. B & G Construction Co*., 8 B.L.R. 1-65 (1985). In other words, a doctor who considers an array of medical documentation that is both long (involving comprehensive testing) and deep (includes both the most recent medical information and past medical tests) is in a better position to present a more probative assessment than the physician who bases a diagnosis on a test or two and one encounter.

The second factor affecting relative probative value, reasoning, involves an evaluation of the connections a physician makes based on the documentation before him or her. A doctor's reasoning that is both supported by objective medical tests and consistent with all the documentation in the record, is entitled to greater probative weight. *Fields v. Island Creek Coal Co.,* 10 B.L.R. 1-19 (1987). Additionally, to be considered well reasoned, the physician's

conclusion must be stated without equivocation or vagueness. *Justice v. Island Creek Coal Co.,* 11 B.L.R. 1-91 (1988).

While Dr. Saxena included black lung as a discharge diagnosis, his opinion lacks probative value because he provided no explanation for his conclusion. Notably, the only reference to black lung in the treatment notes other than the discharge diagnosis is the physician's annotation that Mr. Wilkinson had a history of black lung. Since Dr. Saxena failed to discuss how the medical evidence developed during Mr. Wilkinson's hospitalization in February 2003 supported a finding of black lung, his discharge diagnosis appears to be based on a reported history of black lung rather than an independent finding by Dr. Saxena.

To the extent Dr. Saxena's medical opinion might have probative weight, it is clearly outweighed by the better documented, reasoned, and correspondingly more probative assessment of Dr. Harnsberger. Dr. Saxena's contact with Mr. Wilkinson lasted one week in the hospital. In contrast, Dr. Harnsberger has treated Mr. Wilkinson for obstructive pulmonary disease since 1992. As the treatment notes demonstrate, as the treating pulmonary physician, Dr. Harnsberger had the best documentation foundation upon which to rest his opinion. Further, Dr. Harnsberger's conclusion that the medical evidence in the record fails to support a finding of coal workers' pneumoconiosis or link coal dust exposure to his pulmonary condition is well reasoned and most consistent with all the medical in the evidence.

Finally, Dr. Harnsberger's opinion does not stand alone. Other than Dr. Saxena, none of the physicians to evaluate Mr. Wilkinson's pulmonary condition have diagnosed pneumoconiosis in either medical or legal terms. Specifically, although Mr. Wilkinson clearly has a disabling obstructive airways disease, Dr. Enjeti, Dr. Goldstein, Dr. Fernandez, and Dr. Mince did not diagnose pneumoconiosis or relate his chronic shortness of breath to his five to six years of coal dust exposure while working on a coal strip mine. In other words, Dr. Harnsberger's well documented and reasoned assessment is additionally supported by opinions of Dr. Goldstein and Dr. Enjeti, who conducted pulmonary examinations of Mr. Wilkinson, as well as the treatment diagnoses of Dr. Fernandez and Dr. Mince. Thus, the preponderance of the medical opinion, including the most probative assessment of Dr. Harnsberger, fails to establish the presence of pneumoconiosis under 20 C.F.R. § 718.202 (a)(4).

CONCLUSION

None of the radiographic evidence establishes the presence of pneumoconiosis. Likewise, the most probative medical assessment of Dr. Harnsberger and the preponderance of medical opinion do not support a finding of either medical or legal pneumoconiosis. Consequently, Mr. Wilkinson has failed to prove the first requisite element for entitlement to black lung disability benefits – the presence of pneumoconiosis. Accordingly, Mr. Wilkinson's claim for black lung disability benefits must be denied.[24]

[24]Since Mr. Wilkinson has failed to prove the first element of entitlement, I need not address the remaining three issues in this case.

ORDER

The claim of MR. SETH W. WILKINSON for benefits under the Act is **DENIED**.

SO ORDERED:

A

Richard T. Stansell-Gamm
Administrative Law Judge

Date Signed: September 22, 2005
Washington, D.C.

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. See 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. See 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board. After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed. At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Donald S. Shire, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. See 20 C.F.R. § 725.481. If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).